# Diabetes Eye Exam Report

**TO:** _____ **Clinic/Office:** _____
**Address:** _____
**Phone:** _____ **Fax:** _____

Patient Name: _____ DOB: _____

Visual Acuity: _____ R _____ L Intraocular Pressure _____ R _____ L

**Retinal Examination Findings:**

_____ No retinopathy or past retinopathy and should be examined in one year.
_____ Needs no laser now, but should return in _____ months because of risk of developing diabetic macular edema (DME) or high risk of proliferative diabetic retinopathy (PDR)
_____ Diabetic macular edema requiring focal laser photocoagulation
_____ High risk proliferative diabetic retinopathy or iris neovascularization requiring panretinal photocoagulation
_____ Tractional retinal detachment or vitreous hemorrhage requiring vitrectomy

**Other Ocular Conditions:**

_____ Not applicable

**Cataracts:**

_____ Does interfere with activities of daily living
_____ Does not interfere with activities of daily living
_____ Not applicable

**Glaucoma:**

_____ Controlled
_____ Sub-optimally controlled
_____ Not applicable

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**Plan of Treatment:** Follow-up _____ weeks/months

_____ Refer to Retina Specialist OR:

(check appropriate treatment plan) (Circle right eye "R" or left eye "L" or both)

| | | | | |
|---|---|---|---|---|
| _____ | Fluorescein angiogram | R | L | B |
| _____ | Panretinal laser photocoagulation | R | L | B |
| _____ | Focal laser photocoagulation | R | L | B |
| _____ | Vitrectomy | R | L | B |
| _____ | Cataract Surgery | R | L | B |
| _____ | Other: | | | |

Eye Care Provider (M.D. or O.D.)

Print Name: _____ Signature: _____ Date: _____

_____ _____ _____
Clinic/Office Name Phone Fax

I give permission to release this information to my Physician _____
Patient Signature